Automobile Accident Questionnaire

Please answer all questions completely

Dear patient: this information is considered confidential. We need this information to better understand the events surrounding your unfortunate trauma, and your answers will help us determine if chiropractic care can help you. In order for us to fully understand your condition, please be as accurate as possible. Thank you.

NAME: ______________________________ DATE: ______________

Accident Information:

Date of Accident: ______________________ City of Accident: ______________________

Accident Description:

1. Position in Vehicle	2. Type of Vehicle	3. What was your vehicle doing?
□ Driver □ Left Rear □ Front Passenger □ Right Rear	□ Car □StationWagon □ Van □ Pickup Truck □ Bus □ Large Truck	□ **Stopped** □ Intersection □ in traffic □at Light □ Turning □ right □ Left □ Parking □ Proceeding along □ Slowing down □ Accelerating

4. Point of impact	5. Details of Accident
□ Head-on □ Rear-end □ Right Side (Passenger) □ Left Side (Driver)	Did you have a seat belt on? □ Yes □ No Does your vehicle have airbags? □ Yes □ No Did your airbag deploy? □ Yes □ No Did you lose consciousness? □ Yes □ No

Where the Police at the scene? □ Yes □ No **Police Report:** □ Yes □ No (If yes, please provide us with a copy)

Additional Description:

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Immediately Following the Accident;

Immediate Symptoms: □ No immediate symptoms □ Headache □ Dizziness □ Neck Pain □ Shoulder Pain □ Arm Pain □ Low Back Pain □ Mid Back Pain □ Buttock Pain □ Leg Pain □ **Numbness** in ○ Right Arm/Hand ○ Left Arm/Hand ○ Right Leg/Foot ○ Left Leg/Foot

Other: ______________________________

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Where did you go after the accident? □ Hospital □ Home □ Work □ Doctor □ Other

How did you get there? □ Ambulance □ Someone else □ Drove yourself

Hospital Visit Information: Hospital Name: ______________ Date ________

Services Received: □ X-rays Region of x-ray: ______________

□ Medication Type of medication: ______________

□ Recommendations: ______________

Doctor Visit Information: Doctor's Name: ______________ Date ________

Services Received: □ X-rays Region of x-ray: ______________

□ Medication Type of medication: ______________

□ Recommendations: ______________

Other: ______________________________

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Since the Accident **Patient:** ______________________________ **Date:** ____________________

Symptoms:

□ Headache	□ Head is heavy	□ Dizziness	□ Buzzing in ears	□ Diarrhea
□ Upset stomach	□ Pins/needles in arms	□ Eyes sensitive to light	□ Loss of memory	□ Cold feet
□ Neck pain	□ Problems sleeping	□ Irritability	□ Ringing in ears	□ Cold hands
□ Neck stiffness	□ Pins/needles in legs	□ Cold sweats	□ Loss of balance	□ Mid back pain
□ Fainting	□ Numbness in fingers	□ Depression	□ Constipation	□ Low back pain
□ Flushed face	□ Numbness in toes	□ Fatigue	□ Loss of smell	□ Tension
□ Nervousness	□ Shortness of breath	□ Chest pain	□ Loss of taste	□ Fever

□ Other: ____

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Were you seen by another Doctor? □ Yes □ No

Name of Doctor: ______________________________ Date of visit: ____________________ # of visits: ______

Services Rec. □ Evaluation □ X-rays □ Medication □Cervical Collar □ Back Brace □ Physical Therapy □ Chiropractic

X-rays Taken: □ Dr's office □ Hospital □ Radiology Ctr. Date of X-rays: ____________________

X-ray region: □ Head □ Neck □ Mid Back □ Chest □Low Back □ Arms □ Legs

Medication: □ Pain killers □ Muscle relaxers □ Over the counter medication (Advil, Tylenol etc.)

Treatments: □ Physical Therapy □ Chiropractic □ Pain Management □Other: ______________________________

Diagnosis: □ Sprain/Strain □ Sciatica □ Disc Herniation □ Contusion □ Fracture □ Other:____________________

Recommended: □ Ice/Heat □ Medication □ Referral to: ____

Other: ____

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Have you ever had complaints in the involved areas before? □ Yes □ No

Have you ever had prior treatment for any same or similar condition? □ Yes □ No

Before the accident were you capable of working on an equal basis with others your age? □ Yes □ No

Are your work or daily activities restricted as a result of this accident? □ Yes □ No

Since the injury are your symptoms □ Improving? □ Getting worse? □ Same?

Other Notes:

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I understand and agree that health and accident policies are in arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assisting in making collection from the insurance company and that any amount authorized to be paid to directly to this Chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: ____

Guardian or Spouse's Signature: ______________________________________ Date: ____________________